SCOTT COUNTY EARLY CHILDHOOD
INTERAGENCY TRANSITION COUNCIL
Staff Questionnaire

Staff: Your answers on this questionnaire will identify your concerns and needs transitioning children from one program to another. The Interagency Transition Council wants to improve the transition process. Check the one that applies ___ Administration; ___Teacher; ___Other

Check the following program(s) that you are currently serving in:	**As Service Provider/Teacher, I have experience working with the following professionals.**
___Hospital (more than 10 consecutive days) ___Home ___First Steps ___Child Care ___Pre-School ___Pre-School Special Education ___Early Head Start ___Head Start ___Kindergarten ___ First Grade ___Special Education (Kindergarten & Elementary age) ___List other _____	___ Physical Therapy ___Occupational Therapy ___Speech-Language Therapy ___Developmental Therapy ___Psychological ___ List other _____ _____

Check the following that apply:

INFORMATION	YES	NO
1. I currently receive information about children from the program that the child last participated in.		
2. The information I receive about the child is sufficient.		
3. I receive information on children's medical needs that affect his/her safety.		
4. I receive an information packet from Head Start for children from that program.		
5. Head Start packets have been helpful.		
6. I would like to receive more information about programs that send children to my program.		
7. I would like to receive more information about programs that receive children from the program that I am in.		
8. I believe that visiting programs that send children to me would be most helpful.		
9. I believe that visiting programs that receive children from the program I am in would be most helpful.		
10. The most helpful way for me to receive information about a child is:		
11. When is the best time for you to receive information about a child?		
COMMENTS:		

Turn the Page Over

Please list the information that you are receiving and information what you would like to receive.

INFORMATION THAT I RECEIVE	INFORMATION THAT I WOULD LIKE TO RECEIVE

Support Services	Yes	No
1. I understand how the services help children.		
2. I know what services are offered/available for the child.		
3. I receive assistance/guidance from therapists as to what I can do to help the child.		
4. I have been given adequate training to know when a therapist could help.		
State any comments on children's services.		

During the last year, what are difficulties/concerns that you have about transitioning of students.

Staff Member Name (Optional) _____ Phone Number (Optional)_____